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## Poliomyelitis in California

### Comparative Incidence for the Epidemiologic Years of 1948 and 1949

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and

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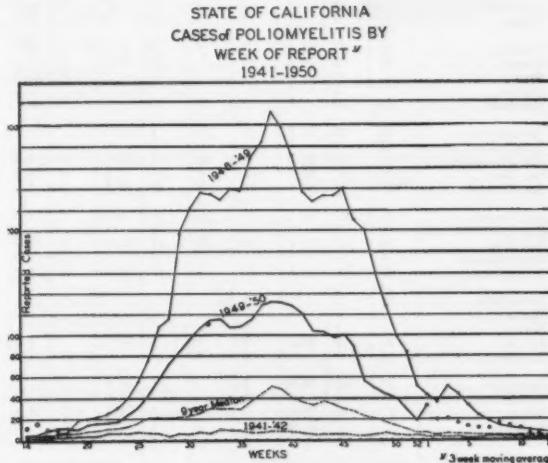
Reported cases of poliomyelitis for the past 10 years show that for the first time we have experienced four years of high incidence in a single decade. Cases have been recorded in California as follows:

Year	Cases	Year	Cases
1940	440	1945	886
1941	232	1946	2,164
1942	330	1947	866
1943	2,650	1948	5,781
1944	459	1949	2,737

The seasonal pattern of cases, as indicated in Graph I, runs from a low point in March through its highest point in August and September, and does not return to the low until the following March. For this reason the epidemiologic year for poliomyelitis is considered as the period beginning with the fourteenth week of the year (in March) and ending with the thirteenth week of the following year (in April). This period is found to be more suitable for the study of poliomyelitis than a calendar year.

The epidemic occurring during the year from April, 1948, to March, 1949, was the highest recorded in this State. It was a severe epidemic, extensive in area involved, and high in percent of cases paralyzed and in fatality.

When an area has experienced such an outbreak, ordinarily one anticipates a low incidence the following year. But, contrary to expectancy, the occurrence for the year 1949-50 was more than twice the expected number of cases as expressed in a nine-year median, and almost half the number experienced in the peak epidemic year of 1948-49.



GRAPH I

NOTE: Dots represent actual reported weekly incidence for the current year.

Because two successive high years are unusual in this State, it was decided to study the records of 1949-50 to determine what similarities and differences might be observed. The sources of data are the morbidity report cards and the supplemental history forms giving paralytic and recovery status. To these are added information from all death certificates in which poliomyelitis is given in the medical certification.

The tables as presented are based on 2,620 reports received between April, 1949, and the end of March, 1950. Among these reports were 15 cases with onset prior to April 1st. Table I shows the distribution of reported cases by county, according to type and severity.



**TABLE I**  
**Reported Cases of Poliomyelitis by Paralytic Status, Percent**  
**Bulbar and Fatality, California Counties**  
**April, 1949-March, 1950**

County <sup>1</sup>	Total cases reported	Total paralytic <sup>2</sup>	Percent paralytic <sup>3</sup>	Non-paralytic	Status unknown	Bulbar cases	Percent bulbar <sup>4</sup>	Fatal cases	Percent fatality <sup>5</sup>
California, total	2,620	1,690	68.4	780	150	448	26.5	109	6.4
Alameda	168	106	63.1	57	5	43	40.5	14	13.2
Alpine	1	1	*	-	-	-	-	-	-
Amador	1	1	*	-	-	-	-	-	-
Butte	10	8	*	2	-	3	*	-	-
Colusa	2	1	*	1	-	-	-	-	-
Contra Costa	92	51	55.4	27	14	17	33.3	6	11.7
Del Norte	1	-	-	1	-	-	-	-	-
El Dorado	3	2	*	1	-	1	*	-	-
Fresno	79	61	77.2	18	-	11	18.0	4	6.5
Glen	4	4	*	-	-	2	*	1	*
Humboldt	38	26	70.2	11	1	9	24.3	3	8.1
Imperial	8	4	*	4	-	1	*	-	-
Inyo	6	4	*	1	-	-	-	-	-
Kern	80	53	67.1	26	1	8	15.0	1	1.8
King	10	7	*	3	-	-	-	1	-
Lake	1	1	*	-	-	1	*	-	-
Lassen	1	-	-	1	-	-	-	-	-
Los Angeles	1,202	766	64.8	415	21	223	29.1	37	4.8
Madera	9	4	*	5	5	-	-	-	-
Marin	20	13	65.0	7	-	4	30.7	3	23.1
Mendocino	4	1	*	1	2	-	-	-	-
Mered	17	8	*	5	4	-	-	-	-
Modoc	1	1	*	-	-	-	-	-	-
Monterey	20	10	*	8	2	4	*	3	*
Napa	6	5	*	1	-	1	*	-	-
Nevada	26	17	65.2	3	6	2	11.7	-	-
Orange	64	45	70.3	19	-	11	24.4	2	4.4
Placer	7	6	*	1	-	1	*	-	-
Plumas	1	1	*	-	-	-	-	-	-
Riverside	36	10	*	7	19	3	*	3	*
Sacramento	46	35	77.7	10	1	4	11.4	-	-
San Benito	3	2	*	-	-	1	*	-	-
San Bernardino	49	29	82.8	6	14	8	27.6	2	6.8
San Diego	99	54	55.6	43	2	9	16.6	8	14.8
San Francisco	119	98	83.7	19	2	12	12.2	5	5.1
San Joaquin	45	41	91.1	4	-	4	9.7	2	4.8
San Luis Obispo	2	2	*	-	-	1	*	-	-
San Mateo	70	31	79.4	8	31	11	35.4	4	12.9
Santa Barbara	19	11	*	1	7	6	*	2	*
Santa Clara	69	50	79.3	16	3	12	24.0	2	4.0
Santa Cruz	12	7	*	5	-	-	-	-	-
Shasta	2	2	*	-	-	-	-	-	-
Sierra	2	2	*	-	-	-	-	-	-
Solano	22	18	85.7	3	1	7	38.8	1	5.5
Sonoma	14	7	*	2	5	3	*	1	*
Stanislaus	39	30	76.9	9	-	11	36.6	-	-
Sutter	3	2	*	1	-	-	-	-	-
Tulare	27	18	75.0	6	3	4	22.2	2	11.1
Ventura	27	12	44.4	12	3	4	33.3	2	16.6
Yolo	12	8	*	4	-	1	*	-	-
Yuba	5	2	*	3	-	-	-	-	-
Not allocated <sup>6</sup>	16	12	*	3	1	5	*	1	*

<sup>1</sup> No cases were reported from Calaveras, Mariposa, Mono, Siskiyou, Tehama, Trinity and Tuolumne Counties.

<sup>2</sup> Paralytic cases—those cases in which definite weakness or paralysis has been detected and persisted during at least two examinations with an interval of at least several hours.

<sup>3</sup> Percent paralytic calculated on cases with known paralytic status.

<sup>4</sup> Percent bulbar includes bulbo-spinal and bulbar cases ratioed to total paralytic cases.

<sup>5</sup> Fatality—deaths per 100 reported paralytic cases—no death occurred in non-paralytic cases.

<sup>6</sup> Represent patients ill before entering State or who contracted illness traveling about the State and not chargeable to any one locality.

\* No percentage calculated when numbers involved were too small (under 20 cases of known status).

#### SEVERITY

The outbreak of 1949-50 was apparently less severe than the one of 1948-49.

1948-49 1949-50

Morbidity rate/100,000	61.2	26.5
Percent with paralysis	72.7	64.5
Percent of paralytic cases with bulbar signs	25.5	26.5
Fatality deaths per 100 paralytic cases	8.8	6.4

As noted, the percent of total paralytic cases with bulbar involvement was slightly higher in 1949-50; but this difference does not prove to be statistically significant.

FATALITY RATES BY TYPE OF PARALYSIS			
Type	No. cases	No. deaths	Percent fatality
1948-49			
Bulbar	1,138	362	31.8
Spinal	3,324	22	0.6
Paralytic, but type not stated	11	5	-
Total paralytic, 1948-49	4,473	389	8.8
1949-50			
Bulbar	448	103	22.9
Spinal	1,242	6	0.5
Paralytic, but type not stated	-	-	-
Total paralytic, 1949-50	1,690	109	6.4

The 1949-50 fatality rate of 22.9 percent in the bulbar group is lower than 31.8 percent in 1948-49. This difference is statistically significant, and represents either more serious bulbar involvement (swallowing mechanism, respiratory center, etc.) in 1948, or greater success in medical management of bulbar cases in 1949. From the available evidence it would appear that the latter is more probable.

#### GEOGRAPHIC DISTRIBUTION

Cases were reported from all but seven counties of the State and, as in the severe epidemic of 1948, these were sparsely populated rural counties.

For purposes of comparison, morbidity rates were calculated by county for the two years. Since we are well aware of the fallibility of population estimates for California counties for any year of this past decade with the extensive in-and-out-migration, no attempt was made to estimate increase or decrease for any county between the two years. The same estimate was used for each year and the rates were expressed in broad step intervals to minimize the error involved. Population estimates served only as a basis for comparison of the two years. No significance can be attached to any single county rate.

#### SEASONAL DISTRIBUTION

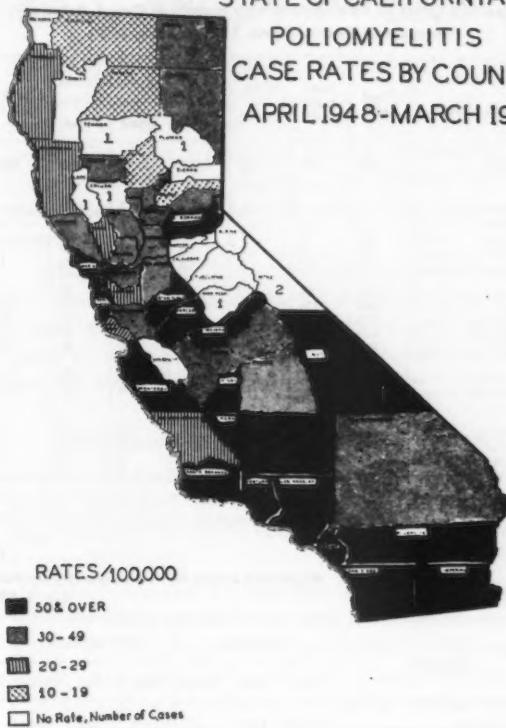
Table II shows the seasonal distribution for the State as a whole during the epidemiologic year 1949-50. September was the peak month for total cases, total paralytic cases and nonparalytic cases. However, when bulbar cases and deaths are considered, it may be seen that July and August produced the largest number of bulbar cases and the peak for deaths (by month of onset of the case) was in July.

Epidemics in this State have always risen more abruptly than they have declined. It would appear from the figures in this table that the incidence of severely paralyzed and fatal cases rises more sharply than the curve for total cases. These differences were

STATE OF CALIFORNIA  
POLIOMYELITIS  
CASE RATES BY COUNTY  
APRIL 1949-MARCH 1950



STATE OF CALIFORNIA  
POLIOMYELITIS  
CASE RATES BY COUNTY  
APRIL 1948-MARCH 1949



not observed in 1948-49, when September was the peak month for all types of cases and for deaths. (See *California's Health*, Vol. 7, No. 7, October 15, 1949.)

#### AGE AND SEX DISTRIBUTION

Table III shows the age and sex distribution for 1949-50. The male/female ratio observed in the 1948-49 data (54 percent of the cases reported were in males, 46 percent in females) is found again in 1949-50 in the ratio of 55 to 45.

The shift of cases to females predominating over males in age groups 20-39 years of age is seen again this year, though not as consistently as in 1948-49.

Tabulations by age and sex were prepared for individual counties, but are not presented in this summary. They are available on request.

Not until 1950 census data are available will age or sex specific rates be calculated. Only then can it be determined whether age-sex differences observed are a function of population distribution or are characteristics of poliomyelitis attack rates.

Paralytic cases, which are subject to much less error of diagnosis than nonparalytic cases, are distributed by broad age groups for the two years, with fatality rates by age. Some interesting differences may be noted.

	Age groups						
	Total all ages	Under 1 year	1-9	10-19	20-29	30-39	40 and over
1949-50							
Paralytic cases.....	1,690	44	861	301	302	143	36
Deaths.....	109	4	36	18	25	20	6
Fatality rate (percentage) .....	6.4	9.0	4.2	6.0	8.2	14.0	16.6
1948-49							
Paralytic cases.....	4,473	138	2,555	738	675	323	44
Deaths.....	389	12	124	83	103	61	6
Fatality rate (percentage) .....	8.8	8.7	4.8	11.2	15.2	18.8	13.6

Percentage distributions show that the proportion of paralytic cases and deaths under age 20 were higher in 1948-49 than last year.

	1948-49	1949-50
Paralytic cases under 20.....	76.7%	71.4%
Deaths under 20.....	56.2%	53.4%

The variation from county to county and from large cities in counties to county areas exclusive of these cities, is shown in Table IV. The areas presented illustrate variability of constants (percent paralyzed, percent with bulbar involvement and fatality) descriptive of a poliomyelitis outbreak. Differences may be observed between different areas in either given year, and between the same areas in the two different years.

#### CONCLUSION

California has just experienced two years of unusual incidence of poliomyelitis. The disease has been widespread—urban and rural, missing only

**TABLE II**  
**Reported Cases of Poliomyelitis by Month of Onset, Paralytic Status and Death—April, 1949–March, 1950**

Month of onset	Total cases	Non-paralytic	Status unknown	Total paralytic	Type of paralysis		Fatal cases <sup>1</sup>
					Spinal	Bulbar	
Total	2,620	780	150	1,690	1,242	448	109
1949							
January	1			1	1		
February	4	1		3	3		
March	10	1	1	8	6	2	
April	29	9	1	19	15	4	1
May	71	30	2	39	31	8	1
June	166	65	10	91	65	26	9
July	400	109	23	268	188	80	22
August	507	175	26	306	225	81	16
September	519	186	22	311	246	65	16
October	392	102	16	274	203	66	10
November	227	48	9	170	115	55	12
December	143	24	13	106	76	30	10
1950							
January	76	16	8	52	33	19	7
February	47	8	13	26	18	8	3
March	23	5	6	12	9	3	2
Not stated	5	1		4	3	1	

<sup>1</sup> Fatal cases are tabulated by month of onset of illness, not by month of death.

**TABLE III**  
**Reported Cases of Poliomyelitis by Paralytic Status, Sex and Age Groups, California April, 1949–March, 1950**

Age groups	Total cases			Spinal paralytic			Bulbar paralytic <sup>1</sup>			Nonparalytic			Status unknown			Fatal cases		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
Total, all ages	* 2,620	1,439	1,177	* 1,242	633	607	448	254	194	* 780	475	303	150	77	73	109	68	41
Under 1 year	55	33	22	36	21	15	8	6	2	9	4	5	2	2		4	2	2
1-4	* 649	371	275	* 378	209	167	73	41	32	* 156	97	58	42	24	18	16	10	6
5-9	* 689	421	267	303	168	135	107	75	32	* 240	157	82	39	21	18	20	16	4
10-14	327	183	144	119	56	63	63	33	30	126	82	44	19	12	7	12	9	3
15-19	196	109	87	73	41	32	46	23	23	65	39	26	12	6	6	6	3	3
20-24	208	89	119	101	38	63	36	19	17	62	31	31	9	1	1	8	10	5
25-29	237	99	138	117	46	71	48	21	27	61	27	34	11	5	6	15	8	7
30-34	124	58	66	60	22	38	28	14	14	32	21	11	4	1	3	10	6	4
35-39	76	43	33	31	18	13	24	13	11	15	9	6	6	3	3	10	5	4
40-44	35	19	16	15	8	7	11	7	4	7	4	3	2	2	2	5	4	1
45 and over	17	11	6	6	5	1	4	2	2	5	3	2	1	1	1	1	1	1
Not stated	7	3	4	3	1	2				2	1	1	2	1	1	1	1	1

<sup>1</sup> Bulbar and bulbo-spinal cases included.

<sup>2</sup> Total includes 4 cases with sex not stated.

<sup>3</sup> Total includes 2 cases with sex not stated.

<sup>4</sup> Total includes 3 cases with sex not stated.

<sup>5</sup> Total includes 1 case with sex not stated.

**TABLE IV**  
**Reported Cases of Poliomyelitis by Paralytic Status, Percent Bulbar and Fatality, Cities of 100,000 and Over Population, Compared With the Remainder of the Corresponding Counties 1948-1949, 1949-1950**

Cities 100,000 and over	1948-1949							1949-1950						
	Total cases	Total paralytic	Percent paralytic <sup>1</sup>	Bulbar cases	Percent bulbar <sup>2</sup>	Fatal cases	Percent fatality <sup>3</sup>							
Total	2,290	1,611	70.3	437	27.1	132	8.2	865	506	58.5	145	28.6	31	6.1
Los Angeles City	1,331	968	72.7	233	24.0	55	5.7	426	202	48.1	78	38.6	10	4.9
Long Beach	229	144	62.8	52	36.1	9	6.2	104	71	74.7	16	22.5	2	2.8
San Francisco	306	204	66.6	57	27.8	25	12.2	119	98	83.7	12	12.2	5	5.1
San Diego City	177	117	66.1	34	29.0	16	13.7	50	29	59.2	5	11.2	4	13.3
Oakland	99	73	73.7	20	27.4	8	10.9	71	49	71.0	13	26.5	5	10.2
Berkeley	43	35	81.3	14	40.0	8	22.8	23	18	78.2	9	50.0	2	11.1
Sacramento City	41	31	75.6	14	45.1	8	25.8	22	14	63.6	3	21.4		
Richmond	64	39	60.9	13	33.3	3	7.7	50	25	50.0	9	36.0	3	12.0
Counties exclusive of above cities														
Total	1,953	1,437	73.6	368	25.6	108	7.5	861	604	72.1	163	27.0	39	6.6
Los Angeles	1,605	1,215	75.7	294	24.2	74	6.9	672	493	74.5	129	26.2	25	5.1
San Diego	172	112	65.1	36	32.1	18	16.1	49	25	52.0	4	16.0	4	18.8
Alameda	68	44	64.7	17	38.6	6	13.6	74	39	54.9	21	53.8	7	17.3
Sacramento	46	26	56.5	10	38.4	5	19.2	24	21	91.3	1	4.7		
Contra Costa	62	40	64.5	11	27.5	5	12.5	42	26	72.2	8	30.7	3	11.3

<sup>1</sup> Percent of total cases which showed some paralysis or weakness.

<sup>2</sup> Percent based on paralytic cases only.

sparserly populated mountain counties. No data received to date indicate a prevalence of confusing viral infectious encephalitides, although these are certainly possibilities.

Over 8,000 cases were reported in this two-year period, with more than 6,000 cases classified as paralytic. (Note definition of paralytic in footnote of Table I.) The outbreak last year was only half that of the year before in number of cases, but, based on past experience, could not be considered a year of average incidence.

What this indicates concerning the pattern of poliomyelitis in this State in 1950-51 cannot be accurately estimated at this time. One can only wait and watch to see what the current year will bring. It would seem prudent for medical planning purposes to anticipate the occurrence of cases in numbers far exceeding the median based on the years 1941-49, if for no other reason than population increases and shifts during those years.

# Highlights of Local Health Officers' Meeting

Decisions bearing on public health policies and practices in California, and representing the fruition of several months' study by working committees of local health officers, were formulated during a productive three-day session of the California Conference of Local Health Officers in San Diego in May. The conference, created by state legislative action in 1947 for the purpose of moulding a pattern of operative standards for local health departments in California, functions principally through its Committee on Administrative Practices. The CAP, in turn, has six major study committees which consider public health matters in their assigned program areas, reporting back through the CAP to the conference for action.

Reports were made to the conference by chairmen of the study committees as follows:

*Environmental Sanitation*, Dr. Edward L. Russell, Orange County; *Health Center Construction*, Dr. Harold D. Chope, San Mateo County; *Maternal and Child Health*, Dr. Ira O. Church, Santa Barbara County; *Disease Control and Laboratories*, Dr. John R. Philp, Butte County; *Recruitment, Training and Personnel Standards*, Dr. Dwight M. Bissell, San Jose; *Records and Reports*, Dr. David Frost, Alameda City.

Dr. James C. Malcolm, Alameda County Health Officer, is chairman of the Committee on Administrative Practices, which consists of 13 local health officers. Dr. W. E. Turner, Santa Clara County Health Officer, is conference president.

Selected highlights from the reports which were adopted by resolution of the conference follow:

## RAW MILK

Recognizing that human consumption of raw milk constitutes a public health hazard, and that there is no state law which prohibits the sale of raw milk, the conference passed a resolution recommending that it be made mandatory that "all milk sold for human consumption in California be pasteurized."

## SUGGESTED IMMUNIZATION SCHEDULE

A suggested routine immunization schedule for preschool and school age children, considered in the interests of effecting uniformity of immunization procedures, was adopted as follows:

*Diphtheria, Whooping Cough and Tetanus*—The initial series of DPT should include a minimum of two injections, preferably three, beginning at three months, with the second dose at four months and the final one at six to eight months of age. Single booster doses of DPT should be given at 18 months and again

during the fourth or fifth year. Further diphtheria and tetanus boosters (one-half of a full dose) should be given at 9 or 10 years of age and again from 13 to 15 years. The later protection against diphtheria is in recognition that this disease is occurring more and more among young adults who have lost earlier immunity.

*Smallpox*—Smallpox vaccination should begin at five months, followed by revaccination at four or five years (prior to the child's entry into school), and again at 10 and at 15. Smallpox vaccination is recommended every five years throughout life.

## QUALIFICATIONS FOR MEDICAL SOCIAL WORKERS

Minimum qualifications for medical social workers to be employed by local health departments were approved by the conference upon CAP recommendation as follows:

*Education and Experience*—Completion of a two-year graduate course in an accredited school of social work with an approved specialization in medical social or psychiatric social work, plus two years of full-time, paid experience in medical social work in a hospital, clinic or public or private medical care program. One year of experience must have been under supervision.

An additional year of supervised experience is recommended if the graduate course in social work is not specialized in medical social or psychiatric social work. Two years of full-time, paid social casework experience in a public or private social agency may be substituted for one year of the nonsupervised medical social work experience.

## LABORATORY SERVICES

The conference recommended a change in public health regulations, as contained in the California Administrative Code, to specify that "in health departments serving a population of 50,000 or more, the laboratory service shall be provided by the health department or by an approved local agency convenient to the health department."

## VENEREAL DISEASE SERVICE

The conference endorsed a CAP recommendation that present venereal disease programs be continued, with particular emphasis on venereal disease education, epidemiology, and expansion of prophylactic treatment. It was suggested that the State Department of Public Health, in conjunction with other interested

agencies, secure and promote an effective film on venereal disease for use by local health departments.

#### OTHER ITEMS

Definition of terms used in describing "contamination" in regards to water pollution was presented in the May 31st issue of *California's Health*.

The conference made a number of recommendations to the State Department of Public Health concerning the setting of priorities and allocation of funds for health center construction. The conference also passed several resolutions recommending certain changes in vital records.

#### Health Officer Changes

Dr. Edith Young, formerly health officer in Sonoma County, has been appointed health officer for the bi-county Sutter-Yuba Health Department, succeeding Dr. Carl A. Scherer. Doctor Scherer resigned his post, which he had held since October, 1945, because of ill health. He is continuing his residence in Marysville. The change became effective June 14th.

Robert S. Westphal, M.D., has been appointed Sonoma County Health Officer. He assumed his new position May 1st, succeeding B. L. Zinnamon, M.D., Acting Health Officer. Doctor Westphal was health officer of Riverside County prior to his new appointment.

#### Dr. Halverson Honored by P. T. A.

A life P. T. A. membership was awarded to Dr. Wilton L. Halverson, Director of the State Department of Public Health, by the California Congress of Parents and Teachers at the organization's recent annual convention in Santa Cruz. Life memberships are awarded for outstanding service to the community and State in the interests of children. Two such memberships were awarded by the state organization this year.

#### Institute on Epilepsy

Among many activities scheduled for San Francisco just ahead of the annual meeting of the American Medical Association June 26th-30th will be the Second Western Institute on Epilepsy, to be held June 25th in Lane Hall, Stanford University Hospital, under sponsorship of the California Society for Crippled Children. The all-day session is limited to professional persons, including physicians, nurses, teachers, social workers, rehabilitation officers, and therapists. Applications should be directed to the CSCC, with \$1 for registration. The institute will be concerned with the diagnostic, therapeutic, educational and social aspects of epilepsy.

#### State Heart Association, C. T. H. A. Terminate Amalgamation

By mutual agreement, the seven-year-old amalgamation of the California Tuberculosis and Health Association and the California Heart Association has been terminated. The CTHA has reestablished direct affiliation with the American Heart Association, and with this fiscal year will undertake its own fund-raising program in California. Since 1943, the CTHA had supported the heart program from the Christmas Seal sale.

According to the announcement of action taken at the annual meeting of the CTHA, "the change in policy of the two associations has resulted from an increased need for additional funds for medical research and program development in heart disease which the Christmas Seal sale alone could not adequately supply without seriously jeopardizing the 46-year-old campaign to stamp out tuberculosis."

Although the administrative disassociation has been effected, the two voluntary agencies will continue their close working relationships, including the use of combined facilities. It has been agreed that local tuberculosis and health associations may continue demonstration heart programs subject to CTHA approval. Where mutual facilities are used, both groups will contribute toward the costs of operation.

Financial disassociation will be gradual, with CTHA support continuing in decreasing measure until March 31, 1953, to assist the CHA and its state-wide affiliates in gaining full maturity. CTHA funds committed to the heart program for the Fiscal Year 1950-51 will continue.

#### L. A. to Hold Administrator Exam

A civil service examination for the position of business manager, Los Angeles City Health Department, will be held July 22d, with final filing date July 12th. Applicants must be college or university graduates with specialization in accounting, law, finance, economics, business or public administration, and must have six years of administrative experience. A thorough knowledge of health department organization and functions as well as other municipal administrative practices is specified. Salary range is \$677 to \$842. All applicants must be residents of the City of Los Angeles at the time of filing.

Oh, health! health! the blessing of the rich! the riches of the poor! Who can buy thee at too dear a rate, since there is no enjoying the world without thee.—*Ben Jonson*.

## Workshop in Community Organization

About 30 state-wide agencies and departments of government and several national organizations will cooperate in presenting the 1951 Claremont Workshop on Community Organization, to be held at Claremont College, Los Angeles County, July 17th-21st. Both lay and professional leaders will participate in discussion groups dealing with community problems.

Conference cost, including board, room, and registration, will total \$25. Roy C. Votaw, California Youth Authority, San Francisco, is secretary of the State Planning Committee on Conferences and Workshops. The Claremont workshop attracts wide attendance from health and welfare fields.

## Post-graduate Cancer Course

A post-graduate medical course in the diagnosis and therapy of cancer, including clinical surgery, radiation therapy and endocrine therapy, is being offered July 17th-22d by the University Extension and the School of Medicine, University of California. The course will be given at the General Medical and Surgical Hospital, Veterans Administration Center, Los Angeles.

## State Civil Service Exams

Civil service examinations for physical and occupational therapists are announced by the State Personnel Board as follows:

*Occupational therapist, and physical therapist*—to be employed in program of services for physically handicapped children. A number of positions are available immediately in conjunction with local school systems. Salary is \$268 to \$325 for both classifications. Entrance requirements include completion of recognized courses in the specialty, plus one year of supervised experience.

*Occupational therapists, Grades 1 and 2*—for employment in state mental hospitals. Salary is \$243 to \$295 for Grade 1, and \$295 to \$358 for Grade 2. Applicants for Grade 1 must have completed a recognized course in occupational therapy. Grade 2 requirements include a year of supervised experience.

Examination dates for California applicants will be July 20th, and the third Thursday of alternate succeeding months, September 21, November 16, and January 18, 1951. Examinations for out-of-state applicants will be held at approximately 60-day intervals beginning July 20th. Applications may be filed anytime with the State Personnel Board, Sacramento.

## N. O. P. H. N. Committeeman

Miss Calista L. Crown, Assistant Chief, Bureau of Public Health Nursing, State Department of Public Health, was elected to serve on the 1950-52 nominating committee of the National Organization for Public Health Nursing, the only Californian to receive a place on the new slate of officers and committees. The election took place at the recent Biennial Convention in San Francisco.

## U. S. Forest Personnel Study Park Sanitation

During the month of April, following a request from the U. S. Regional Forester's Office, a series of one-day meetings on environmental sanitation were held in the supervisors' headquarters of the following National Forests: Mendocino, Angeles, San Bernardino, Cleveland, Sequoia, Six Rivers, Trinity and Lassen.

These meetings brought together forest supervisors and their staffs of rangers with representatives of county, state and federal health agencies for a brief in-service training session in sanitation, at the same time providing a common meeting ground for all interested agencies in the matter of recreational sanitation in the forests.

The 18 national forests in California cover one-fifth of the area of the State, and last year had a total of 16,000,000 recreational visits by the public. This tremendous recreational activity is creating a multitude of sanitation problems for the Forest Service, which has requested the closest collaboration of county and state health departments. The recent meetings served as an approach to the problem in helping to determine what can be done and what should be done toward a large scale sanitary improvement program.

In addition to the foresters, the meetings were attended by the county health officers of San Diego, Tulare, and Humboldt-Del Norte; the directors of sanitation of Colusa, Los Angeles, San Bernardino, Riverside, Orange, San Diego, Kern, Tulare, Humboldt-Del Norte, Butte and Plumas Counties; a representative of the Regional Office of the U. S. P. H. S. and representatives of the Bureau of Sanitary Engineering, the Bureau of Vector Control and the Division of Local Health Service.

The Forest Service has requested, through the Division of Local Health Service, that similar meetings be held next fall for the 10 remaining forests.

Since no one else will leave so indelible a stamp upon the child, parents are key health educators.—*Health Education Journal (London)*, April 1950

## A Community Job

Community-wide organization for health education provides one sure way in which people can come together to think, plan and act together to improve personal and public health. It provides a total community approach to community-wide problems. It involves the individual members of the community in surveying community health needs and in creating community support as a prelude to community action in accordance with citizen needs and wishes. A widely representative community health council is democracy's highway to integrated community health effort; its formation should be viewed as the takeoff point, never as the destination.—*Connecticut's Health Bulletin*, May, 1950

## Food Handling Guide

A guide for the teaching of food handling and sanitation for commercial establishments has been published jointly by the State Department of Public Health and the State Department of Education. This 114-page mimeographed booklet not only presents content material for food handling courses, but devotes sections to the organization of local programs and to teaching techniques.

Use of the guide has been discussed in a series of five institutes which have reached sanitarians and health educators throughout the State. These institutes were held under sponsorship of the State Department of Public Health, beginning March 7th in San Jose and continuing at two-week intervals in Sacramento, Fresno, Los Angeles City and Los Angeles County.

## Traffic Safety Honor Roll

With a record of no traffic fatalities during 1949, eight California cities have won places on the Honor Roll of the National Safety Council, which lists 504 cities throughout the country with populations between 5,000 and 10,000 with similar records. Appearing on the honor roll are Antioch, Coalinga, Hanford, Martinez, Orange, Pacific Grove, San Anselmo, and Santa Clara.

Despite modern methods of controlling infection, puerperal septicemia still accounts for about one-third of all deaths associated with childbearing. Many of these deaths could be prevented by better prenatal care.—*National Office of Vital Statistics*

## California Morbidity Reports Selected Diseases—Civilian Cases

Total Cases for April and Total Cases for January Through April  
1950, 1949, 1948 and Five-Year Median (1945-1949)

Reportable diseases	Current month				Cumulative			
	April			5-Yr. median 1945- 1949	January through April			
	1950	1949	1948		1950	1949	1948	1945- 1949
Amebiasis	33	35	22	23	133	126	100	77
Anthrax				2	2	2	2	2
Botulism				2	2	2	2	2
Brucellosis (undulant fever)	8	13	10	18	31	33	43	77
Chancroid	20	46	41	46	85	210	167	191
Chickenpox	4,568	7,143	7,054	7,054	18,236	27,341	23,059	28,000
Cholera								
Coccidioidomycosis, disseminated	9	7	4	13	32	30	18	18
Conjunctivitis, acute infectious of newborn		1	3	2		3	7	1
Dengue								
Diarrhea of the newborn	15	4	1	1	43	17	87	97
Diphtheria	35	34	31	73	152	170	215	279
Encephalitis, infectious	7	2	2	2	32	15	9	12
Epilepsy	156	196	128	131	752	809	657	615
Food poisoning	128	38	15	41	880	221	41	138
German measles	283	4,178	682	2,071	1,067	12,796	1,715	6,004
Gonococcal infection	1,564	1,585	2,230	2,230	4,712	7,657	9,137	9,137
Granuloma inguinale	1	2	4	4	7	12	19	19
Hepatitis, infectious	34	59	3	16	136	203	31	31
Influenza, epidemic	64	78	135	135	295	577	14,345	577
Leprosy			3	1	2	3	7	3
Leptospirosis (Weil's disease)					2			
Lymphogranuloma venereum	15	15	31	17	38	81	106	51
Malaria		1	3	3	9	14	31	31
Measles	2,530	8,276	14,694	8,276	5,672	29,510	31,911	26,449
Meningitis, meningococcal	15	24	22	33	119	129	173	173
Mumps	5,035	5,555	4,662	4,662	18,751	20,356	13,150	13,150
Pertussis	923	209	418	418	2,559	968	1,330	1,330
Plague								
Pneumonia, infectious	153	177	174	179	890	801	841	874
Poliomyelitis, acute anterior	47	30	9	19	244	346	53	11
Poitacocosis	3	2	1	1	3	3	4	3
Rabies, animal	9	20	26	32	21	86	127	127
Rabies, human		1						
Relapsing fever								
Rheumatic fever, acute	63	45	72	72	194	244	320	283
Rocky Mt. spotted fever								
Salmonella infections *	40	17	7	7	60	27	20	20
Shigella infections (bacillary dysentery)	11	19	24	19	143	94	101	94
Smallpox								
Streptococcal infections:								
Scarlet fever	458	338	365	637	2,221	1,724	1,654	2,056
Streptococcal sore throat (and "septic sore throat")	62	83	44	44	311	300	224	224
Syphilis	904	1,029	1,512	1,982	2,834	5,053	5,996	7,988
Tetanus	2	6	2	4	12	14	9	17
Trachoma	2	1		1	7	3	8	8
Trichinosis	2		8	2	7	2	11	8
Tuberculosis:								
Respiratory	691	689	628	689	2,117	2,760	2,700	2,700
Other forms	55	52	42	52	115	151	181	151
Tularaemia								
Typhoid fever	6	5	9	9	25	31	44	21
Typhus fever		1	2	1		1	5	10
Yellow fever								

\* All types of salmonella infections now reportable. Prior to January 1, 1950, only A, B and C types were reportable; hence a five-year median not entirely comparable.

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